COMMITTEE ON DENTAL AUXILIARIES

PART IV. ASSESSMENT OF THE NEED TO REGULATE

- **PROTECTION OF THE PUBLIC HEALTH AND SAFETY**
- **THE PRACTITIONER IN CALIFORNIA**
- **REGULATORY ACTIVITIES IN OTHER STATES**

SECTION 1. PROTECTION OF THE PUBLIC HEALTH AND SAFETY

The purpose of regulating RDAs, RDHs, and EFs is to assure the public that dental auxiliary professionals, upon whom the public depends for health care, meet minimum levels of competency. Dental care treatment is among the more intimate types of treatment that people receive since it entails highly intrusive work inside the mouth.

Technological advances, the differing dental needs of an aging and diverse society, and increasing concerns about the transmission of infectious diseases have all increased the need for regulation. As the trend continues toward the performance by auxiliaries of even more complex duties, and reduction of the level of dentist supervision, regulation will be even more imperative.

Both the scrutiny of educational programs and the examination/qualification process protect the public by assuring that auxiliaries who perform certain intra-oral procedures are competent to perform them on patients in a manner that is both safe and hygienic. In addition, the license renewal process ensures that auxiliaries have completed required continuing education courses to keep their knowledge current.

It is normally assumed that (1) the cost of regulation is passed on to the public by any licensed practitioners; and, (2) regulation by its very nature restricts the supply of practitioners and, therefore, may result in regulated practitioners charging more for their services

With regard to dental auxiliary employees, it is unlikely that the above factors significantly impact the price of dental services. In fact, if procedures must be repeated because unregulated, incompetent auxiliaries perform them improperly, the cost of dental care will most

likely increase, both to consumers and California's Medi-Cal program.

CONSUMER HARM

The harm that can result from the improper performance of procedures by auxiliaries includes the following:

- ***Physical injury and death*** can occur through improper performance of dental procedures, through aspiration into the lungs or ingestion of dental materials; misuse of sharp instruments, caustic agents, local anesthetics, or other dental materials; or, failure to take a proper medical history and/or assure appropriate premedication has occurred.

- ***Later physical harm*** can occur, which is difficult if not impossible for the consumer to detect nor attribute to the incompetence of an auxiliary. As a simple example, improperly tied orthodontic archwires, over a period of time, can cause actual root resorption and loss of teeth years later.

- Patients and others can be harmed through the performance of procedures without the ***proper handling and disposal of hazardous wastes*** such as bodily fluids and tissue, mercury, acids, and contaminated needles.

- Patients and others can be harmed through the performance of procedures without carefully following prescribed infection control procedures, which can result in the ***transmission of an increasing variety of infectious and deadly diseases***, including HIV, AIDS, hepatitis B and C, and tuberculosis.

- ***Unseen financial harm*** can occur to consumers through the incorrect performance of procedures, since the procedure must be repeated for an acceptable result. When this occurs on more than a rare basis, the over-all cost of dental services to the consumer rises.

Following are examples of the skills required in performing a few auxiliary duties, and the resulting consequences of improperly performed services:

CONSEQUENCES OF IMPROPERLY PERFORMED PROCEDURES

	Procedural Example	Potential Consequences
1.	Conduct of a comprehensive health history: a. to observe necessary precautions related to specific medical problems, such as premedications for valvular heart disease, hip replacement, or history of rheumatic fever. b. to aid in identifying the need for anti-infective precautionary measures, such as hepatitis, where disease transmission to others during the infectious state is extremely high. c. to observe necessary precautions related to medications, such as allergies to antibiotics	 a. Bacterial endocarditis, which can cause infection and destruction of heart tissue, resulting in fever, anemia, loss of appetite, fatigue, and sudden death. Left undiagnosed and untreated, the patient's life expectancy seldom exceeds 3-6 months. b. Hepatitis disease transmission from patient to patient or patient to clinician, which can severely damage the liver. c. Anaphylactic shock requiring cardiopulmonary resuscitation and the attention of an emergency rescue team.[1]
2.	Administration of local anesthesia and vasoconstrictors with consideration of the patient's current physical state, medication regime, age, and psycho/emotional state.	Exaggeration of existing Ischemic heart disease, hypertension, or cardiac arrhythmias. Increases potential of stroke with those who have prior history.[2]
3.	Administration of local anesthesia with understanding of anatomy of the nervous, vascular, osseus, and muscular structures of the head and oral areas to determine which injections should be given and which techniques used.	Transient facial nerve paralysis, muscle trismus or soreness after injection, vessel ruptures causing internal bleeding and hematomas, toxic overdose, syncope (fainting), allergy, idiosyncrasy, intraoral lesions, localized infection.[3]
4.	Administration of topical anesthetic agents.	Toxic reactions, tissue irritation or tissue damage.[4]

[1] Comprehensive Dental Hygiene Care, 4th Edition, by Irene R. Woodall RDH, Ph.D, Chapter 6 with 29 additional references, 1993.

[2] Ibid. Chapter 32 with 34 additional references

[3] Ibid.

[4] Ibid.

5.	Administration of nitrous oxide (laughing gas) with careful patient assessment and selection.	Misuse can affect memory, reaction time, temperament, and coordination. For those with unscavenged nitrous oxide a significant reduction in probably of conception.[5]
6.	Ultrasonic scaling, which is commonly used as an adjunct to manual scaling to remove deposits.	Communicable diseases can be disseminated by aerosols. May interfere with cardiac pacemakers. May damage primary/newly erupted teeth by overheating pulpal tissues. Will damage titanium implants.[6]
7.	Coronal polishing to remove extrinsic stains.	Bacteremia can be created for those patients who have damaged or abnormal heart valves, prosthetic valves, total joint replacements, rheumatic heart disease, congenital heart disease, cardiac bypass, and cardiac shunts. Abrasive agents can embed in and irritate tissues and hinder healing for patients who have had root planing or who have enlarged inflamed gingival tissue. Overpolishing removes the surface layer of tooth structure where the fluoride content is greatest and can increase caries in susceptible teeth.[7]
8.	Taking radiographs to identify decay, cysts, tumors, and other abnormalities by using a minimum amount of radiation to gain the maximum amount of diagnostic information.	Poor chairside techniques necessitates retakes which unnecessarily exposes the patient to additional cumulative radiation. Overexposure may result in: - the alteration or destruction of living cells or impaired tissue function - physiological tissue mutations which may be manifested in succeeding generations.[8]

[5] Ibid. Chapter 33 with 49 additional references.

[6] Mosby's Comprehensive Review of Dental Hygiene, Third Edition, by Michele Leonardi Darby, B.S.D.H., M.S., p. 537, Mosby, 1994.

[7] Comprehensive Dental Hygiene Care, 4th Edition, by Irene R. Woodall, RDH, Ph.D, Chapter 30 with 80 additional references, Mosby, 1993.

[8] Radiology for Dental Auxiliaries, 2nd Edition, by Herbert H. Frommer, Chapter 4 with 12 additional references, Mosby, 1978.

DENTAL CONSUMERS LACK ABILITY TO JUDGE QUALITY OF CARE

Unlike practitioners in many of the health care professions, dental auxiliaries cannot readily be evaluated by most consumers. The patient lacks the technical expertise to evaluate what dental care has been performed in his/her mouth, and whether it has been performed properly. Most often, the consumer is not even able to see the areas treated. Unless there is considerable pain and visible trauma to the treated area, usually the consumer will not question the treatment nor be able to assess the adequacy of treatment.

A recent survey conducted by the California Dental Association[9] found that patients expect good work and do *not* feel able to judge the quality of dental work. A 1994 Gallup Poll found that dentistry is the third most trusted profession in America, which, coupled with the consumer's inability to make judgments about the quality of delivered care, makes consumers even more vulnerable.

In addition, the public ***expects*** dental auxiliaries to be licensed in the State of California. According to a survey of California consumers conducted in the Summer of 1996, 98% felt that dental assistants who worked inside their mouths should be licensed in California, with 95% responding that they would feel unsafe without the licensing requirement.

As stated in other parts of this report, the trend in other states and countries is toward increasing the number of duties which auxiliaries can perform, expanding the types of locations where they can be performed, and relaxing the supervision levels under which they are performed.

Relaxation of such restrictions may decrease the cost of dental care to the general public, and increase access to care to underserved segments of the population, such as children, the elderly, minorities, rural, low income, and homebound people.

If such advances continue in California, licensure will be even more critical. Deregulation at this time would eliminate an important mechanism to gauge the current competency of auxiliaries with a view towards whether they can practice safely in an even more expanded role of service to the public.

PRACTITIONERS WITH CRIMINAL BACKGROUNDS

The licensure process also prevents criminals convicted of sexual misconduct or substance abuse from working on patients. Employers of auxiliaries do ***not*** have the legal means to access auxiliary criminal history records in order to make an assessment of their fitness to work on patients safely.

[9] March 1995, "The Dental Care Behavior and Attitude of Californians", conducted by Lawrence Rubin Inc.

SECTION 2: THE PRACTITIONER IN CALIFORNIA

There are approximately 38,000 auxiliaries currently licensed in California: 25,000 RDAs, 13,000 RDHs, and 400 EFs. There are about 29,000 licensed dentists in California. In 1993, the average national wage was $11 per hour for assistants and $20 per hour for hygienists; the national average net income for a dentist general practitioner was $107,000 and for a specialist dentist $160,000.[11] Auxiliaries are nearly all women, while dentists are predominantly men, although approximately 35% of students currently in dental schools nationwide are women.

DESCRIPTION OF SCOPES OF PRACTICE

Dental auxiliaries perform duties as employees of licensed dentists, receiving a salary based either on hours or number of patients seen. Duties are performed in dental offices or in legally specified alternative facilities. Each category of auxiliary is allowed to perform a variety of technically complex and intrusive procedures on patients, as specifically delineated in regulation.

The trend in other states and countries has been to increase the number of duties which auxiliaries can perform, expand the types of locations where they can be performed, and relax supervision levels. A 1994 survey by the Council on Dental Practice of the American Dental Association found that a majority of dentists would like the authority to delegate more procedures to dental assistants, if they completed appropriate school-based training.[13]

Increased scopes of practice and relaxation of setting and supervision restrictions may decrease the cost of dental care to the general public, and increase access to care to underserved segments of the population, such as elderly, minority, rural, low income, and homebound people.

For example, a 1980 Report to the U.S. Congress by the Comptroller General concluded: "Extensive research and experience show that employing expanded function dental auxiliaries under dentists' supervision to complete restorations (fill teeth)...is one way of increasing the efficiency of the Nation's dental care delivery system and providing needed services to more people at less cost."[14]

[11] American Dental Association

[13] Council on Dental Practice, *Study of Dental Support Personnel*, Supplement to the Annual Reports and Resolutions, 1994, American Dental Association, Chicago, 1994.

[14] Report to the Congress of the United States, "Increased Use of Expanded Function Dental Auxiliaries Would Benefit Consumers, Dentists, and Taxpayers", Comptroller General, March 7, 1980.

The Committee on Dental Auxiliaries recommended shortly after its formation in the early 1970's that certain auxiliaries be allowed to perform restorative work, and the Department of Consumer Affairs sponsored unsuccessful legislation in the late 1970's (AB974-Rosenthal) which would have licensed dental auxiliaries to deliver “reversible” procedures including placement, condensation, and carving of amalgam (a filling) in prepared cavities under the general supervision of a dentist. At this time, no legislation has passed in California to allow auxiliaries to fill teeth. Auxiliaries in Colorado, Indiana, Kentucky, Ohio, Pennsylvania, Washington, and Wyoming can place, carve and condense fillings, while several other states allow performance of certain portions of that procedure.

An occupational analysis of RDH and EF practitioners currently being conducted may result in recommendations to expand scopes of practice of auxiliaries and/or reduce the level of dentist supervision.

Supervision Levels

All of the duties performed by auxiliaries, as detailed later in this section, are done under two types of supervision, specified in regulation:

- Direct supervision requires that the dentist be physically present in the office or treatment facility during the performance of specified procedures, based on instructions given by the dentist;

- General supervision allows the performance of specified duties without the presence of the dentist in the office or treatment facility, based on instructions given by the dentist.

In dental practice, the term “supervision” does not have the same connotation as used in everyday language. During the performance of “direct supervision” duties, for example, it is not common practice for the employer dentist to give detailed instructions prior to the auxiliaries’ performance of a procedure, or for the dentist to hover nearby as the procedure is performed. The same is true for “general supervision duties”.

Instead, it is common for the dentist to diagnose and prepare a treatment plan, without giving any instruction on how the procedure to be performed by the auxiliary is to be completed. While the dentist must be in the treatment facility during the performance of “direct supervision” duties, he or she is most often engaged in performing dental procedures on other patients at the same time. During the performance of general supervision duties, the dentist need not even be in the office nor accessible for consultation.

In 31 states, dental hygienists can now practice under general supervision in all settings. In Washington, they can practice unsupervised in some settings, while in Colorado hygienists can practice unsupervised in all settings.

The Office of Statewide Health Planning and Development (OSHPD) authorized Health Manpower Pilot Project #139 (HMPP 139), which allowed certain dental hygienist practitioners

to operate independently in California beginning in 1988. The final evaluation of HMPP#139 by OSHPD concluded that allowing hygienists to practice without dental supervision increases dental care access, that hygienists participating in the project were much more likely to accept Medi-Cal patients than California dentists, and that, on the average, the hygienists charged considerably less per visit that did dental offices for the same types of services. HMPP#139 was replaced by a similar project, HMPP #155, which began in 1990 and is currently operating.

Unlicensed Dental Assistant Duties

A dental assistant performs chairside supportive procedures and general office procedures. This category of auxiliary is not licensed, and the responsibility for assessing and monitoring the assistant's competency rests solely with the dentist. All intra-oral procedures performed by unlicensed assistants must be done under direct supervision (the dentist must be in the facility), and be checked and approved by the dentist prior to dismissal of the patient from the office.

A dental assistant may perform any extra-oral procedure, and the following intra-oral procedures:

- Take impressions for diagnostic and opposing models;
- Apply non-aerosol and non-caustic topical agents, and apply topical fluoride;
- Remove post-extraction and periodontal dressings, and remove sutures;
- Take intra-oral measurements for orthodontic procedures, examine orthodontic appliances, remove arch wires and ligature ties, place elastic orthodontic separators, remove all types of orthodontic separators, and seat adjusted retainers or headgears;
- Assist in the administration of nitrous oxide analgesia or sedation;
- Place and remove rubber dams and matrices;
- Cure restorative or orthodontic materials with a light-curing device;
- Exposure of radiographs, if certified to do so

Registered Dental Assistant (RDA) Duties

This category of auxiliary must be licensed by the Board, after meeting minimum education and/or experience qualifications and passing the RDA licensing examinations, as described in the licensing and examination sections of this report.

An RDA may perform all of the functions delegated to a dental assistant. In addition, an RDA may perform the following procedures under direct supervision:

- Test pulp vitality;
- Place bases and liners on sound dentin;
- Remove excess cement from supragingival surfaces of teeth with a hand instrument or floss;
- Size stainless steel crowns, temporary crowns and bands;
- Temporary cementation and removal of temporary crowns and removal of orthodontic bands;

- Place orthodontic separators, and place and ligate arch wires;
- Placement of post-extraction and periodontal dressings;
- Take bite registrations for diagnostic models for cast study only;
- Coronal polishing (after completion of a board-approved course);
- Removal of excess cement from coronal surfaces of teeth under orthodontic treatment by means of an ultrasonic scaler (after completion of a board-approved course);
- Obtain endodontic cultures;
- Dry canals with absorbent points.

Under general supervision (the dentist need not be in the treatment facility), an RDA may perform the following duties:

- Mouth-mirror inspection of the oral cavity, including charting of obvious lesions, existing restorations and missing teeth;
- Placement and removal of temporary sedative dressings.

Registered Dental Hygienist (RDH) Duties

An RDH may perform all of the functions an RDA is allowed to perform and, in addition, may perform the following under direct supervision:

- Periodontal soft tissue curettage;
- Administration of local anesthetic agents, infiltration and conductive, limited to the oral cavity;
- Administration of nitrous oxide and oxygen when used as an analgesic.

In addition, an RDH may perform the following duties under general supervision (the dentist need not be in the treatment facility):

- Removal of lime deposits, accretions and stains from the unattached surface of the teeth, root planing, and application of topical agents essential to complete prophylaxis;
- Polish and contour restorations;
- Oral exfoliative cytology;
- Apply pit and fissure sealants;
- Preliminary examination, including, but not limited to, periodontal charting, intra and extra-oral examination of soft tissue, charting of lesions, existing restorations and missing teeth, classifying occlusion, and myofunctional evaluation;
- Take impressions for diagnostic and opposing models;
- Remove post-extraction and periodontal dressings, and remove sutures;
- Take intra-oral measurements for orthodontic procedures, examine orthodontic appliances, remove ligature ties, and place elastic separators.;
- Test pulp vitality;
- Remove excess cement from supragingival surfaces of teeth;
- Size stainless steel crowns, temporary crowns and bands;
- Temporary cementation and removal of temporary crowns and removal of orthodontic bands;
- Place post-extraction and periodontal dressings.

Registered Dental Assistant in Extended Functions (RDAEF) Duties
Registered Dental Hygienist in Extended Functions (RDHEF) Duties

A licensed RDA may become licensed as an RDAEF, and a licensed RDH may become licensed as an RDHEF, after meeting certain educational requirements and passing the EF licensing examination, as described in the licensing and examination sections of this report. An RDAEF may perform all of the duties that an RDA is allowed to do, and an RDHEF may perform all of the duties that an RDH is allowed to perform, as well as the following more complex duties, under direct supervision:

- Cord retraction of gingivae for impression procedures;
- Take impressions for cast restorations, space maintainers, orthodontic appliances and occlusal guards.
- Prepare enamel for bonding by etching;
- Formulate indirect patterns for endodontic post and core castings;
- Fit trial endodontic filling points;
- Apply pit and fissure sealants (an RDH may perform this duty without obtaining an EF license)

Settings of Auxiliary Practice

All auxiliaries are required to perform allowable functions in a treatment facility under the jurisdiction and control of the supervising licensed dentist, or in an equivalent facility approved by the board.

In addition, under the same degree of supervision specified for each duty above, an RDH may perform duties at licensed health facilities, clinics, and community care facilities as defined in Sections 1250, 1203, and 1502 of the Health and Safety Code, public and private schools of any grade level, public institutions, including but not limited to federal, state and local penal and correctional facilities, mobile units operated by a public or governmental agency or a nonprofit and charitable organization approved by the board, health fairs or similar non-profit community activities, or the home of a non-ambulatory patient.

ASSESSMENT OF COMPETENCY

Since the duties which auxiliaries may legally perform are specifically delineated in statute and regulation, it is relatively easy to determine the knowledge, skills and abilities required to perform those functions.

Through occupational analyses and consultation with educational experts, the requisite skills and abilities to perform those duties are continually assessed and examinations revised to assure their relevance. The ability of potential practitioners are then evaluated through the licensure examinations to assure minimal competency.

REGULATION BY OTHER ENTITIES

It is unknown what percentage of auxiliaries may be licensed by other agencies. However, such licensure, if any, would be in an area unrelated to dentistry and would not represent "over-lapping" licensure.

All dental practitioners must comply with Cal-OSHA and Fed-OSHA which establish standards for a safe environment for employees. In addition, if an auxiliary wishes to practice in another state he or she must conform to the statutes and regulations of that state. All practitioners are also impacted by The Patient Protection Act of 1990, which mandated state licensing boards to establish infection control guidelines for all dental health care providers, and the Centers For Disease Control (CDC) guidelines for practice procedures to prevent the transmission of diseases.

PROFESSIONAL ASSOCIATIONS

Practitioner groups and associations include the following:

- ***State Organizations:***

  California Dental Assistants Association (2,228 members) - Kristy Borquez, President, (209) 227-4220

  California Association of Dental Assisting Teachers (119 members) - Lana Wright, President, (510) 676-4661

  California Dental Hygienists Association (3,600 members) - Katie Dawson, President, (916) 442-4531

  California Dental Hygiene Educators Association (80 members) Jean Rice, President, (209) 271-0541

  California Orthodontic Assistants Association (250 members) Carolyn McVey, President, (818) 709-5585

- ***Local Organizations****:*

- Berkeley Dental Assistants Society, Channel City Dental Assistants Society, Diablo Dental Assistants Society, Eastland Dental Assistants Society, Fresno-Madera Dental Assistants Society, Harbor Dental Assistants Society, Marin County Dental Assistants Society, Monterey County Dental Assistants Society, Orange County Dental Assistants Society, Professional Association of North Coast Dental Assistants, Pomona Valley Dental Assistants Society, Rio Hondo Valley Dental Assistants Society, San Diego County Dental Assistants Society, San Fernando Valley Dental Assistants Society, San Francisco Dental Assistants Society, San Gabriel Valley Dental Assistants Society, San Mateo County Dental Assistants Society, Santa Clara County Dental Assistants Society, Santa Cruz County Dental Assistants Society, South Alameda County Dental Assistants Society, Tulare-Kings Dental Assistants Society

- Central Coast Dental Hygienists' Society, East Bay Dental Hygienists' Component, Kern County Dental Hygienists' Society, Long Beach Dental Hygienists' Society, Los Angeles Dental Hygienists' Society, Monterey Bay Dental Hygienists' Component, Mt. Diablo Dental Hygienists' Society, Peninsula Dental Hygienists' Component, Redwood Dental Hygienists' Society, Sacramento Valley Dental Hygienists' Component, San Diego County Dental Hygienists' Society, San Fernando Valley Dental Hygienists' Society, San Francisco Dental Hygienists' Society, San Gabriel Valley Dental Hygienists' Society, San Joaquin Valley Dental Hygienists' Association, Santa Barbara Dental Hygienists' Society, Santa Clara Valley Dental Hygienists' Association, Six Rivers Dental Hygienists' Component, South Bay Dental Hygienists' Society, Tri County Dental Hygienists' Society, Valley Oaks Dental Hygienists' Association, Ventura County Dental Hygienists' Society

- ***National Organizations****:*

American Dental Assistants Association, Jennifer Blake, President, (312) 541-1550

American Dental Hygienists' Association, Ann Battrellstilwell, President, (312) 440-8900

SECTION 3: REGULATORY ACTIVITIES IN OTHER STATES

LICENSURE REQUIREMENTS

All states and territories regulate dentists and hygienists. States other than California regulate dental assistants to varying degrees as shown in Table N below.[15]

Table N. Types of Duties Auxiliaries are Allowed to Perform in the United States

	Calif. RDA	*Calif. AEF*	*# of Other States*	*Formal Training*	*Exam*
Inspect oral cavity	yes	yes	20	4	3
Apply topical anesthetics	no	no	36	5	5
Remove excess cement from coronal surfaces	yes	yes	38	12	9
Cement bands/bond brackets	no	no	4		
Bend archwires	no	no	9	2	1
Expose radiographs	yes	yes	47	27	27
Test pulp vitality	yes	yes	11	6	6
Prepare alginate impression for study casts	yes	yes	43	10	6
Coronal polishing	yes	yes	23	12	9
Apply topical anticarciogenic agents	yes	yes	33	10	9
Apply pit and fissure sealants	no	yes	19	12	8
Place periodontal dressings	yes	yes	25	10	9
Remove periodontal dressings	yes	yes	37	12	10
Remove sutures	yes	yes	40	11	10
Place matrices	yes	yes	31	12	10
Place and remove rubber dams	yes	yes	41	13	11
Place temporary restoration	yes	yes	22	9	6
Apply cavity liners and bases	yes	yes	11	6	4
Place amalgams (fillings)	no	no	10	3	3
Condense and carve amalgams (fillings)	no	no	4	1	1
Polish amalgams	no	no	15	9	7
Place/pack restraction cord	no	yes	11	4	2

[15] Legal Provisions for Delegating Functions to Dental Assistants and Dental Hygienists, 1993, American Dental Association, Chicago.

As stated earlier, the trend in other states and countries has been to increase the number of duties which auxiliaries can perform, expand the types of locations where they can be performed, and relax supervision levels. A 1994 survey by the Council on Dental Practice of the American Dental Association found that a majority of dentists would like the authority to delegate more procedures to dental assistants if they completed appropriate school-based training.

Dental hygienists in California and other states have sought legislative change to allow them to perform certain procedures without the oversight of a dentist. In 31 states, dental hygienists can now practice under general supervision in all settings. In Washington, they can practice unsupervised in some settings, while in Colorado hygienists can practice unsupervised in all settings. Hygienists are allowed to provide services in alternative settings without the presence of a dentist in 42 states.

As noted in a report submitted to Congress in 1995 by the **Secretary of the Department of Health and Human Services**, "1993, Ninth Report to Congress, Health Personnel in the United States":

"*Presently, dental hygiene services are largely confined to private dental offices because of supervision requirements which differ from State to State and hinder hygienists' ability to disperse throughout the community and thereby improve access to oral health care."*

ORGANIZATIONAL STRUCTURES

The state of New Mexico recently established an RDH Committee separate from the Dental Board, with complete authority for the regulation of dental hygiene. Washington State has two dental boards: one for examination and one for discipline. They also have a separate dental hygiene examining committee which directly advises the Director of Health rather than the dental board. In Maryland, Committee members are also members of the Dental Board.

The states of Florida, Texas, Delaware, and Arizona all have separate auxiliary committees similar to California. In Florida and Delaware, proposals are being considered to increase the powers of their Committees.

The Secretary of the Department of Health and Human Services "1993, Ninth Report to Congress, Health Personnel in the United States", noted:

"For its part, ADA has opposed self-regulatory proposals arguing that it would lead to independent practice and that 'unsupervised or independent practice by dental hygienists reduces the quality of oral health care and seriously increases risks to patients.' These claims, however, appear unsupported by any data."

Independent sunset reviews in the 1990's in Maryland, Arizona, and Hawaii all recommended substantial increases in auxiliary membership on the governing boards.

SUNSET REVIEWS

Fifty percent (50%) of State Boards relating to dentistry are subject to sunset review with a large majority of the remaining Boards subject to legislative audit. Those that have undergone sunset review have been re-enacted.

In a 1991 sunset review report to the **Maryland** legislature prepared by the independent Department of Fiscal Services of the Maryland Board of Dental Examiners, it was found that:

"Deregulation of the practice of dentistry and dental hygiene clearly poses a danger to the public. ...The results of a recent poll of citizens of Maryland conducted by the Department of Fiscal Services indicates that 95% of respondents felt that dentists should be regulated, while 94% felt that dental hygienists should also be regulated. Generally, respondents believed that regulation ensures high quality care, a steady supply of competent providers, and protection to the public from incompetent practitioners."

In a 1993 sunset review report to the **South Carolina** legislature, the independent Legislative Audit Council similarly recommended continued regulation of dentists and dental hygienists, and also concluded:

"Although we recommended in our 1987 sunset report that dental assistants be required to pass a valid proficiency examination prior to being considered qualified to practice, the board decreased the qualification requirements...By removing the requirement that dental assistants be certified and by allowing individuals with no training to perform such procedures as removing sutures and taking and recording vital signs, the board has lessened the quality of services and reduced protection of the public health and safety."

Accordingly, the report recommended that the Board require more stringent qualifications of dental assistants who perform procedures not normally performed by untrained personnel in other states, and require national certification of individuals performing expanded dental assisting duties.

In its October, 1993, Sunset Evaluation Update report on dental hygienists to the Governor and Legislature, the Auditor of the State of **Hawaii** found that even though hygienists worked under direct supervision, and they had found no evidence that hygienists had caused past injury to patients:

"*The Legislature should...continue the regulation of dental hygienists. The practice of dental hygiene could harm the public's health, safety, and welfare. Incompetent dental hygienists could injure patients. Dental hygienists perform procedures that can damage the tissue of the*

mouth or transmit infectious diseases (a growing concern with the spread of the HIV virus). Providing inadequate care to such high-risk patients as those with diabetes, heart problems, and hemophilia could result in serious health problems."

In 1993, a bill re-establishing the Texas Board of Examiners during a sunset review process went unsigned and the Board officially closed August 31, 1994. "This was due in large part to unresolved disputes over the composition of the Board by the Texas Dental Association and Texas Dental Hygienists Association.[16] A Texas District Judge ruled that the state legislature had to reconstitute the Board since the Dental Practice Act required dentists and dental hygienists to be licensed, but without the Board there was no process to obtain or renew such licenses.

[16]CLEAR News, Winter, 1994, Volume XI, No. 4, Council on Licensure, Enforcement and Regulation, p. 1